Modern Healthcare

Maryland's bold payment reforms blaze a path, but will others follow?

By Melanie Evans | January 23, 2016

Former Maryland Gov. Martin O'Malley brought up his state's experiment of setting budgets for all hospitals during the Jan. 17 Democratic debate in Charleston, S.C. Getty Images

The Democratic presidential candidates sparred vigorously over healthcare in their most recent debate. Front-runners Bernie Sanders[1] and Hillary Clinton[2] dominated the exchange, so talk of Maryland's singular hospital payment reform ended almost as quickly as it started.

Not that Martin O'Malley didn't try to tout Maryland's bold experiment on the national stage. “I have to talk about something that's actually working in our state,” said the presidential hopeful and former Maryland governor. O'Malley cut off Sanders. Moderator Andrea Mitchell cut off O'Malley.

“Andrea, Andrea, Andrea,” he interjected

and quickly made a case for the Maryland model. In 2014, the state started to regulate hospital spending after nearly four decades of setting hospital prices for all payers, public and private.

Maryland's reforms won praise from Clinton. “And that's exactly what we are able to do based on the foundation of the Affordable Care Act. What Gov. O'Malley just said is one of the models that we will be looking at to make sure we do get costs down, we do limit a lot of the unnecessary costs that we still have in the system,” she said.

But she quickly turned her attention back to Sanders, who just hours before the debate, released more information about his single-payer healthcare proposal, which he calls “Medicare for all.”

Pundits and policy experts have generally dismissed the Sanders plan as a political nonstarter and still too vague on details to accomplish a transformation of the U.S. healthcare system far more complex than what's currently underway with the Affordable Care Act.

So what is happening in Maryland? And is it a good idea for it to be a national model?

“It could be done in any state in the union,” said Dr. Robert Berenson, an Urban Institute senior fellow and former CMS official. Look abroad for evidence that governments could do more to regulate health spending, he said, “It could be done.”

But that would take significant political will by states to more actively regulate hospitals, he said, which all states but Maryland abandoned. Maryland is also still an experiment, with encouraging early numbers, but no guarantee of success.

The state started setting hospital rates for private payers in 1974 and three years later won permission from the federal government to also set rates under **Medicare**[3] and **Medicaid**[4]. Maryland policymakers say that move has erased the cost-shifting that most U.S. hospitals rely on to make up for low rates from public payers.

Although the all-payer model allowed Maryland to significantly reduce its costs per admission, growth in the volume of admissions undermined its broader success in holding down spending.

So in 2014, Maryland agreed to set a budget for each hospital for all patients. The budget includes payment from every insurer. The state also promised that the budget would not grow faster than the state economy each year. A commission tracks hospital bills, hospital prices and patient volume. It also makes complex adjustments to account for very sick patients, transfers between hospitals, flu outbreaks and other factors that can increase or decrease demand for hospital services.

Maryland and federal officials hope that hospitals will work hard to stay under budget by avoiding unnecessary hospital care, and the state has pledged to save Medicare $330 million over five years.

The state's previous rate-setting system did nothing to control how many patients were admitted to hospitals or how much care hospitals provided, so spending soared.

“If you can only sell pants for $2, you will need to sell a lot of pants,” Joshua Sharfstein, former secretary of the Maryland Department of Health and Mental Hygiene, told the Urban Institute last November.

“Global budget is a huge shift,” Sharfstein said in an interview. He is now associate dean for public health practice and training at Johns Hopkins University.

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Maryland may be giving other states a blueprint for aggressively regulating the way hospitals do business, but following it would require significant political will.

Hospitals no longer need to stay full to make money, he said; keeping beds full was the business model when hospitals got paid per admission. A global budget allows care to be delivered elsewhere with the goal of keeping people out of the hospital instead.

“Healthcare should be organized to promote prevention and better health, as much as it is to provide high-quality care for people who are really sick,” Sharfstein said.

Other states could follow Maryland's strategy, though most probably won't regulate prices, he said. But global budgets could still work on their own. “I think the appetite for rate-setting isn't as high as the appetite for global budgets,” he said.

In Maryland, some early results are promising. Hospital spending grew more slowly

than the economy in the first year. Hospitals also saved Medicare an estimated $116 million in 2014, state and federal officials reported in the New England Journal of Medicine in November last year.

Other results are mixed. The rates dropped for some conditions that can be avoided with prevention and quality improvement efforts. But infections from central venous catheters and catheter-related urinary tract infections went up, not down.

And some of the results were just plain bad. Patient-experience scores across the state are among the nation's worst. Hospital admissions and repeat visits improved but remained above the U.S. average. Spending per Medicare enrollee in 2014 remained higher than almost every other state.

Oversight of the budget by an independent commission is a complex undertaking. Notably, Maryland must monitor hospital volume and decide when increases and decreases are warranted.

For example, hospitals could see more patients than projected under their budget because of market-share gains or a bad flu season. Hospitals could see fewer patients because of successful efforts to reduce avoidable admissions.

But hospitals could also try to game the system, and Maryland officials are tasked with trying to tell the difference. “I think that's a very interesting experiment,” Berenson said.

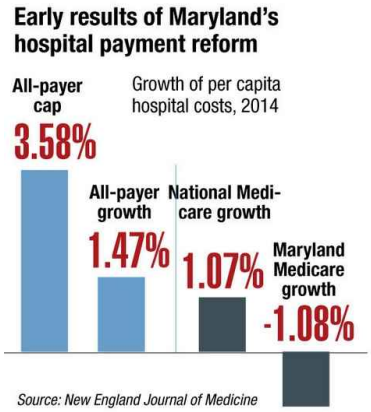
Maryland sees competition for market share as one of the program's strengths. Hospitals have an incentive under the global budget to vie for customers on patient satisfaction, quality and price.

Hospitals can increase rates by up to 5% within their budget, and up to 10% with regulatory approval. “But they are still in a competitive market and may not want to have rates that high,” John Colmers told the Urban Institute in November. Colmers is chairman of the Maryland Health Services Cost Review Commission, which sets rates for all payers.

Early performance suggests hospitals have done well so far. Their financial performance improved or remained the same in 2014, the first year the state used the new budgets, said hospital analyst Stephen Infranco, a director at Standard & Poor's.

Better cost control has encouraged investments in ambulatory care, as Maryland hospitals seek to treat patients in the least-costly setting. “They're all trying to figure that out,” Infranco said.

Hospitals have also benefited from predictable budgets. “It certainly is easier to budget if you know what your revenues are going to be next year,” said Eva Thein,



a senior director at Fitch Ratings. “Volumes have been volatile in different parts of the country and in different parts of Maryland.”

Bon Secours Baltimore Health System came in under budget the first two years and reduced its number of potentially avoidable conditions and readmissions, said Samuel Ross, CEO of the Baltimore-based hospital.

The fixed budget allowed the hospital to hire patient liaisons who coordinate care and resources when patients leave the hospital and return home, he said.

Liaisons work with patients to overcome barriers, including health literacy, transportation and navigating follow-up appointments. “It's providing those supports beyond the walls of the hospital that help to ensure that they won't come back” or reduce that likelihood, he said.

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